Tachycardia – Pediatric 3.6P

EMT/ADVANCED EMT STANDING ORDERS

E/A

- Routine Care.
- 12-lead ECG if available.

PARAMEDIC STANDING ORDERS

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If symptomatic and hemodynamically unstable:

For narrow complex/probable SVT:

- Adenosine 0.1mg/kg IV not to exceed 6mg (first dose).
  - Repeat once at 0.2mg/kg not to exceed 12mg (subsequent dose).
- If adenosine is ineffective or for wide complex, perform synchronized cardioversion:
  - 0.5 – 1J/kg; if unsuccessful, increase to 2J/kg.
- Administer procedural sedation prior to or during cardioversion, if feasible:
  - Midazolam 0.05mg/kg IV/IN (maximum dose 2.5mg), may repeat once in 5 minutes **OR**
  - Diazepam 0.05mg/kg IV (maximum dose 2mg), may repeat once in 5 minutes.

If symptomatic but hemodynamically stable:

For narrow complex, probable supraventricular tachycardia, or regular wide complex tachycardia (monomorphic QRS ONLY):

- Adenosine 0.1mg/kg IV not to exceed 6mg (first dose).
  - May repeat once at 0.2mg/kg IV not to exceed 12mg (subsequent dose).
- **For wide complex:**
  - Contact online **Medical Control** for consideration of amiodarone 5mg/kg IV (maximum: 300mg) over 20-60 minutes.

PEARLS:

- Consider and treat potential underlying causes, e.g., hypoxemia, dehydration, fever.
- Signs and symptoms of hemodynamic instability:
  - Hypotension
  - Acutely altered mental status
  - Signs of shock
- Probable Sinus Tachycardia:
  - Compatible history consistent with known cause
  - P waves are present and normal
  - Variable R-R and constant P-R interval
  - Infants: rate usually <220/min
  - Children: rate usually <180/min
- Probable Supraventricular Tachycardia:
  - Compatible history (vague, nonspecific); history of abrupt onset / rate changes
  - P waves absent / abnormal
  - Heart-rate is NOT variable
  - Infants: rate usually >220/min
  - Children: rate usually >180/min
  - Adenosine should be administered rapidly though a proximal (e.g., antecubital) vein site followed by a rapid saline flush